EHR: Three implementation stories from the CDI front lines

First came the computerized physician order entry (CPOE) system. Next staff implemented an electronic query/CDI system. Finally there was a move to a full electronic health record (EHR). When Emory University Orthopedic & Spine Hospital in Tucker, Ga., decided to phase out various elements of its traditional, paper medical record charts, it took things one piece at a time, says Linda Franklin-Yildirim, RN, CCDS, a CDI specialist at the facility.

Unfortunately, integration of the various systems was far from seamless. For example, after composing a query, Franklin-Yildirim and her CDI teammates would have to leave a query notification in the EHR system’s “inbox” for the physician, and then send the physician a pager message letting them know a query was waiting for them.

“That’s how long ago we’re talking,” she says with a laugh. “We were on pagers! The physician would get our message, and they would go open their inbox and document their response in the medical record if applicable.”

At the time, the physician query response rate was as low as 63%, Franklin-Yildirim says. To combat this problem, the team held in-services to explain how to access the queries and maneuver within the EHR. Their response rates began to steadily improve—today it’s roughly 98%.

The initial struggle for Emory’s CDI staff was getting the query into a user-friendly format for the physicians. “They want to make their records as complete as possible, but it has to be simple for them,” says Franklin-Yildirim. “CDI specialists really need to be the ones to help on this. We need to make those highlighted points as to how to use the system and why it’s necessary, to make it as easy and convenient as possible for them.”

Today, Emory’s physicians understand how to navigate the EHR and can access their queries from their inbox at their convenience. Some physicians opt to respond after they get out of surgery, while others send Franklin-Yildirim their answers late in the evening.

“For them, it’s about finding what suits their workflow and lifestyle,” she says. “If it’s convenient for them, I’ll get query responses sometimes at seven or eight at night.”

The key to successful implementation, Franklin-Yildirim says, is the same no matter the project: Enlist individuals who have energy and passion for the project to participate in the rollout, educate peers, and work with the team to seek methods of process improvement.

“Once they see how successful it can be, everyone wants to get on board,” she says.

Simplifying the process

When Bernadine Darienzzo, RN, CCDS, CDI supervisor at Boston Medical Center (BMC), started at the 496-bed academic facility three years ago, the team had to carry their laptops to the hospital floors due to a lack of available floor computers and work space. This arrangement led to communication problems. Laptop batteries would run out in a matter of hours, and it proved difficult to review charts and engage in conversations with the physicians during patient rounds.

“We tried to tag along, but rounds are fast paced and focused on daily orders and discharge planning. Physicians had mostly just come from seeing their patients, so they were not going directly back to the charts. It just wasn’t the place or time for us,” she says. “It just wasn’t efficient or productive.”

BMC is a private, not-for-profit facility and one of the busiest trauma centers in New England, says Darienzzo. The physicians supported the new program, but they felt it was disrupting patient care.

As BMC became one of Boston’s first facilities to integrate an EHR, the CDI process migrated away from a floor-based approach. CDI specialists took to their own offices and attached queries to emails. Physicians had 24 hours to respond, and the team would send a reminder text message to their pagers. If a physician did not respond, he or she would receive another pager message and a follow-up email.

“This was just such an involved process,” Darienzzo says, “and we wanted to improve our productivity as well as our physician response rates.”

After BMC migrated to a fully electronic query system, Darienzzo and her team didn’t rely on the new program to solve their query problems. She worked with BMC’s IT team and the vendor to ensure physicians received queries in an effective yet unobtrusive manner. The IT team made sure that whenever physicians entered the EHR to update their progress notes, they first saw the queries attached to the note. They
would read the content of the query, then scroll down to write their note.

According to Darienzzo, the positive outcomes of this new process were immediately apparent. They included:

» A 70% decrease in follow-up queries

» A 98% physician query response rate

» Giving physicians the ability to respond to queries when and where they document their progress note (e.g., in the office, at home, or on the floor) rather than having to remember a query and find it in an alternative system.

Now BMC is embarking on an even bigger EHR shift—transitioning multiple electronic software systems to one comprehensive vendor over a two-year period. Two physicians on the planning committee were adamant that they did not want to lose the convenience of the current query interface, so Darienzzo and her team have a seat at the transition planning table.

Thankfully, she says, the team is analyzing the workflow to see how CDI specialists interface with the electronic systems and how that information flows to physicians and coders. “They really want to match interface to interface,” Darienzzo says.

Those seeking to emulate BMC’s EHR success story may opt to follow Darienzzo’s two-part advice. First, she says, find a supportive IT partner who will listen to your needs and help you brainstorm solutions. Second, remember your own mission and keep physicians engaged by focusing on the mission and not the almighty dollar.

Connecting systems at the start

The 300-plus bed Sibley Memorial Hospital, a member of John Hopkins in Washington, D.C., specializes in obstetrics, oncology, and orthopedics. Like many facilities, Sibley struggled at the outset of EHR implementation to bring the various facets of multiple systems together into one unit.

“The ED has one system, the radiology department uses something else, and billing and finance have yet another,” says Mark N. Dominesey, RN, BSN, MBA, CCDS, CDIP, CHTS-CP, MCP, who now works as the director of auditing and CDI services for Trust HCS in Washington, D.C.

At Sibley, Dominesey explained how CDI fit into the EHR implementation process and worked to gain allies within the IT, HIM, and finance departments to prove that CDI specialists needed to be involved. He also strove to identify opportunities for collaboration with IT staff to develop simple and effective in-house solutions where vendor products proved too costly and/or cumbersome for the overall system.

CDI specialists need to serve as subject matter experts to advocate for systemwide standards for certain controversial clinical conditions, such as acute respiratory failure, sepsis, and acute kidney disease—much as they would when developing systemwide query forms, Dominesey says.

Additionally, CDI staff can help IT integrate likely clinical scenarios based on indications, medications, and other documented conditions. Finally, they can help integrate necessary ICD-10-CM/PCS elements and craft easy-to-use query templates.

Since physicians have become used to CDI specialists as their go-to documentation team, most of them feel comfortable working through the EHR processes with the specialists. CDI staff can provide physicians and other clinical staff with information regarding EHR use and resource management; they can also help clinicians see how their documentation gets reflected in quality ranking scores.

“Having a designated CDI person as an EHR documentation resource person is a great idea, but that responsibility should be written into a new staff member’s job description so that aspect doesn’t overwhelm their typical chart review priorities,” notes Dominesey.

Although some may be “clinging to the paper chart, the pre-EHR world just isn’t viable anymore. However, if physicians are forced to point and click their way through the EHR, then we will lose any of the benefit associated with the transition,” Dominesey says. “CDI principles have to be included during the outset of the process, and ongoing assessment of those tools needs to be developed into an additional CDI target area. CDI principles need to be baked into the electronic solution and not be sandwiched in later as an afterthought.”

EDITOR’S NOTE
Franklin-Yildirim is a former leader of the Georgia ACDIS chapter. She related her experiences with electronic query implementation to the group during its fall 2013 meeting. Darienzzo presented a poster on this topic at the 2013 ACDIS national conference in Nashville. Dominesey was a speaker at the 2013 ACDIS conference. ACDIS members can download his PowerPoint presentation from the Forms & Tools Library at www.acdis.org.